South Carolina Law Review

Volume 13 | Issue 1 Article 9

Fall 1960

Insurance

Wesley M. Walker

INSURANCE

WESLEY M. WALKER*

The cases for review during this survey year do not contain any startling departures from previously established rules and decisions. The Courts have aided the practitioner by interpreting several of the provisions found in standard policies. The decisions for review under this section are not as numerous as in years past but, once again, are greatly diversified, thus making classification difficult.

Procedure

Only one decision requires attention under this classification and the same case will no doubt be discussed elsewhere in this survey under the topic, *Pleading*. That decision was *Vanderford v. Smith*[1], in which the Court held that, under the authority of *Brown v. Quinn*,[2] an insurance company which had allegedly filed a policy of liability insurance on behalf of the plaintiff, a taxicab company, pursuant to an ordinance of the City of Union, was properly impleaded for the purpose of a counterclaim filed by the original defendant. The counterclaim contained allegations that the ordinance of the City of Union, which had licensed the plaintiff taxicab company for operation, required that all operating taxicabs be insured in specific amounts against liability for damages to persons or property and, further, that Canal Insurance Company, which the defendant sought to implead, had filed a liability policy pursuant thereto. The Supreme Court held that, for the purposes of the motion to implead, these allegations of the counterclaim were deemed to be true and that, accordingly, the lower Court's denial of the motion was error.

Fraud and Misrepresentation

In *Reid v. George Washington Life Ins. Co.*,[3] our Supreme Court held that no cause of action had been stated by the plaintiff. The attempted action was against a health and

*Member of the firm of Leatherwood, Walker, Todd & Mann, Greenville; A.B., 1936, University of South Carolina; LL.B., 1938, University of South Carolina; Attorney, City of Greenville, 1949-51; member Greenville County, South Carolina and American Bar Associations.

1. 235 S. C. 448, 111 S. E. 2d 777 (1960).
2. 220 S. C. 426, 68 S. E. 2d 326 (1951).
3. 234 S. C. 599, 109 S. E. 2d 577 (1959).

hospital insurer and the Complaint alleged that there was fraud by the insurer's sales agent in misrepresenting the coverage afforded by the policy. The lower court sustained a demurrer to the complaint on the ground that, even if the insurer's sales agent had been guilty of fraud in misrepresenting to the insured the extent of the coverage provided by the policy, the insured had held the policy for seven years before she discovered what the coverage actually was and that she had, therefore, failed to take advantage of her opportunity to learn what her contract provided.

The Supreme Court affirmed, holding that the complaint did not state a cause of action within the rule of *Thomas v. American Worker*[4] and *Shumpert v. Service Life & Health Company*,[5] because it did not contain any allegations of ignorance, illiteracy or incapacity of the insured from any cause at the time she procured the policy or afterward.

In *Blackmon v. United Insurance Co.*[6] the action was for the alleged fraudulent breach of a contract of life insurance accompanied by a fraudulent act. After the death of the insured, the beneficiary contacted the insurer's agent and furnished the insurer with proof of the death of the insured, which proof indicated that the insured had been older than the age stated on his application for the insurance. The agent stated to the beneficiary, and to other witnesses who testified at the trial that, upon the beneficiary's surrender of the policy and furnishing of the proof of death, he would bring to the beneficiary a check for the face amount of the policy, to-wit, two hundred dollars ($200.00). Instead, the agent returned with a check for one hundred and forty odd dollars explaining that such amount was all the beneficiary was entitled to under the policy because of the difference in the age of the insured-decedent as shown on his application for the insurance and as shown on the documents in support of the proof of death.

The Court held that these facts, as proved upon trial, were not sufficient to support a verdict for punitive damages and the verdict of the lower court as to punitive damages was reversed. However, the Court held that there was a conflict in the proof as to the age of the decedent and, accordingly, the matter was properly submitted to the jury

4. 197 S. C. 178, 14 S. E. 2d 886, 136 A. L. R. 1 (1941).
5. 220 S. C. 401, 68 S. E. 2d 340 (1951).
6. 235 S. C. 335, 111 S. E. 2d 552 (1959).

which had determined this issue adversely to the insurer-appellant. Consequently, the verdict for actual damages in the face amount of the policy was affirmed.

The Court pointed out that Section 37-161 of the Code limits the time within which the insurance company may dispute the truth of the application to a period of two years after the issuance of a policy of life insurance, but pointed out that this section also provides that, when the age of the person insured has been misstated, the company may at any time adjust any amount payable or benefit accruing under the policy to such as the premiums would have purchased based on the true age of such insured. The Court stated that the insurer was within its legal rights to so adjust the amount payable under the policy, and that fraud was not to be implied where one acted within his legal rights.

Disability Benefits

In *Dunlap v. Metropolitan Life Insurance Co.*,[7] the appeal was from the refusal of the lower court to require the insured, a dentist, to produce records showing his income from sources other than work or occupation, such as his outside investments and the sale and purchase of stocks and bonds. The insured had been receiving benefits under the subject policy because of his total incapacity to carry on his activities as a dentist. The Supreme Court affirmed the lower court's refusal to require the insured to produce these records stating that:

> The fact that an insured receives income from sources other than work or occupation does not preclude his recovery of disability benefits . . . . The insurer's contention here would lead to the strange result that a bedridden, professional man is not totally disabled from performing gainful work because he receives a substantial income from purchasing and selling stocks and bonds.

The Court, accordingly, held that the records sought to be produced were wholly irrelevant to the issues in the case and the trial court properly refused to order their production.

Policy Interpretation

In *Pardee v. Fidelity & Casualty Co. of New York*,[8] the Court had before it the interpretation of the following provisions of an automobile liability policy:

7. 235 S. C. 206, 110 S. E. 2d 856 (1959).
8. 235 S. C. 521, 112 S. E. 2d 497 (1960).

Part 1—Liability

* * *

to pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of:

* * *

B. injury to or destruction of property including loss of use thereof, hereinafter called 'property damages';

* * *

Exclusions

This policy does not apply under Part 1:

* * *

(g) to injury to or destruction of property owned or transported by the insured, or property rented to or in charge of the insured, other than a residence or private garage.

* * *

While the insured automobile was being driven by the plaintiff, Mrs. Beatrice C. Pardee, the accelerator stuck causing her to run into a garage, damaging the garage in the amount of three hundred and fifty dollars ($350.00). (Although not stated, it is apparent that this garage was owned by Mrs. Pardee.) The insurer refused to make payment for the damage done to the garage and suit was brought to recover for the same and also for the alleged improper cancellation of the policy.

The insured contended that the exclusion (g) set forth above was not applicable because damage to a residence or private garage was excluded from the exclusion. The insurer contended that "a residence or private garage" was excluded from the exclusion only when such residence or private garage came within the definition of "property rented to or in charge of the insured".

The Court decided that the words "other than a residence or private garage" when considered in conjunction with "property rented to or in charge of the insured" provided coverage that the insured would not have had otherwise and that the opinion of the Court was that the intention of the parties was that the words "other than a residence or private garage" did not apply to property owned by the insured but

were intended to provide coverage to the policyholder in case of liability for damage to "property rented to or in charge of the insured". The Court further pointed out other provisions of the policy whereby the insurer agreed "to pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages" and stated that, ordinarily, one does not become legally obligated to pay himself for damages. The Court, accordingly, held that the defendant's motion for non-suit as to the first cause of action should have been granted.

In *Campbell v. Calvert Fire Ins. Co.*,[9] our Supreme Court laid down the rule relating to the measure of damages to which an insured is entitled under the standard automobile collision policy. The Court said that in such instances, where there is a partial loss and the damaged vehicle can be repaired and restored to its former condition and value, the cost of repairs is the measure of liability, less any deductible sum specified in the policy. However, where the repairs do not place the vehicle in its former condition and value and, after repairs have been made, there remains a loss in actual value, the insured is entitled to compensation for such deficiency. The Court stated that under these circumstances, some Courts adopt as the measure of damages the difference between the fair cash value of a car before and after the collision while other Courts achieve substantially the same results by adding any diminution in value to the cost of repairs. Our Court stated that either of these methods assures fair protection under a policy of this kind and that which of the two methods is preferable depends largely upon the facts of each particular case but that, of course, under either, there should be deducted the amount specified in the policies as a deductible feature.

The case of *Robinson v. Georgia Casualty & Surety Co.*[10] was tried on the circuit without a jury on a stipulation of facts before the Honorable Bruce Littlejohn. Insofar as is here pertinent, the following facts appear to have been undisputed:

Napoleon Truesdale owned a 1956 model Chevrolet automobile. Eugene Truesdale, son of Napoleon Truesdale, did not own an automobile. His driver's license had been cancelled

9. 234 S. C. 583, 109 S. E. 2d 572 (1959).
10. 235 S. C. 178, 110 S. E. 2d 255 (1959).

because of a conviction of driving under the influence and it was necessary that he have evidence of financial responsibility in order to obtain a driver's license. Accordingly, he purchased from Georgia Casualty and Surety Co., hereinafter referred to as Georgia Casualty, an automobile liability insurance policy. At his request, the Georgia Casualty agent filed with the South Carolina Highway Department what is commonly known as SR-22, which was a certification that Eugene Truesdale was covered by the policy, and on the strength of which the driver's license was issued to him. The application for the insurance policy indicated that an owner's policy was desired, and it was an owner's policy that the agent issued. Subsequent to Eugene Truesdale's purchase of the Georgia Casualty policy, Napoleon Truesdale traded in the 1956 Chevrolet and purchased a 1958 Chevrolet which was likewise registered in his name. He gave to his son, Eugene, the unrestricted right to use the 1958 Chevrolet. On the evening of December 18, 1957, Eugene Truesdale asked his friend, Alonzo Robinson, to take the 1958 Chevrolet and go to the home of Yvonne Mungo. Inez Williams was riding in the car with Alonzo Robinson, and in the course of this trip an accident occurred resulting in her death. Eugene Truesdale was not in the automobile at the time of the accident.

Suit was thereafter instituted on behalf of the Estate of Inez Williams against Alonzo Robinson, Napoleon Truesdale and Eugene Truesdale. Eugene Truesdale and Alonzo Robinson, through their attorney, transmitted the summons and complaint to Georgia Casualty, but Georgia Casualty refused to undertake the defense of the action asserting that there was no coverage as to the automobile described in the complaint.

Negotiations were begun whereby the attorneys for the estate offered to settle the case for the sum of $4,500.00, which was within the limits of the coverage provided by the policy of Georgia Casualty. Eugene Truesdale and Alonzo Robinson called on Georgia Casualty to pay the sum demanded and advised that Georgia Casualty would be held for any excess judgment under the familiar Tyger River principle. The settlement was not concluded and, thereafter, an affidavit of default as to Alonzo Robinson was filed, and the case as to him was referred to a referee. After a reference was held, the referee recommended that the plaintiff have judgment

against the defendant, Alonzo Robinson, in the sum of $25,000.00 and an order for judgment by default against Robinson in that amount was entered. Robinson then filed this action against Georgia Casualty seeking to have the judgment paid.

Judge Littlejohn's Order was adopted as the opinion of the Supreme Court. He held that the fact that the Georgia Casualty policy was certified to the State Highway Department as evidence of the financial responsibility of Eugene Truesdale in order to allow him to obtain his driver's license had no bearing on the case. The Judge cited Section 46-750.22 of the Code which lists the requirements of an owner's policy and which provides that the policy must by explicit language describe the motor vehicle to be covered by the policy and that the policy must contain an omnibus coverage clause. The Georgia Casualty policy which was issued as an owner's policy fully met the requirements of this Code provision and the trial judge held that Eugene Truesdale, insofar as the statute was concerned, was covered so long as he was operating the 1956 Chevrolet described in the policy and that, likewise, Alonzo Robinson would have been covered while operating this 1956 Chevrolet with the permission of Eugene Truesdale.

Section 46-750.23 of the Code was referred to as listing the requirements of an operator's policy. That section only requires that an operator's policy shall insure the named insured against loss from liability imposed upon him by law for damages arising out of the use by him of any motor vehicle now (sic) owned by him. The Court stated that, although the Acts of 1952 also used the word "now", the context requires that the word be read as "not". The trial judge held that, should it be concluded that because of the fact Eugene Truesdale did not own the 1956 automobile, the policy, in effect, became an operator's policy, it would afford coverage only when Eugene Truesdale was operating the automobile and that there was no reason of public policy or otherwise which would require that Robinson be clothed with the protection of the statute required only in the case of Eugene Truesdale. For these reasons, the trial judge concluded that the safety responsibility statute was not to be considered and that a decision would be dependent upon the terms and provisions of the policy itself.

Georgia Casualty's policy was a standard owner's policy containing the usual definition of insured which included the

insured and anyone using the automobile with the permission of the named insured. The term automobile was defined as being either the automobile described in the policy or a newly acquired automobile. Newly acquired automobiles were defined as being one which is acquired by the named insured if it replaced an automobile owned by the named insured.

The Court, therefore, concluded that Robinson was not covered by the insurance policy because the automobile was clearly not the one described in the policy and that, further, it could not qualify as a newly acquired automobile because of the requirement that such be an automobile *ownership of which is acquired by the named insured* and only where it *replaces an automobile owned by the insured and covered by the policy.* Neither of these two requirements had been fulfilled and, hence, there was no coverage.

In *Crook v. State Farm Mutual Automobile Ins. Co.*[11] the insurer contended that it was not liable under its automobile liability policy because of the breach by the insured of the cooperation clause of the policy. In this decision our Supreme Court firmly commits itself to the rule that an insurer must be substantially prejudiced by the failure of the insured to cooperate and that the insured's violation of the cooperation clause would constitute a defense available to the insurer only where the insurer could show by the preponderance of the evidence that such violation substantially prejudiced its position. The Court also stated that this issue constituted a question of fact to be determined by a jury.

Insured's False Swearing or Misrepresentation

In *State Farm Fire & Cas. Co. v. Herron*[12] the insured had made application with the insurer to purchase fire insurance, stating in the application that there was no other insurance on the property. Thereafter, a fire of unknown origin totally destroyed the insured dwelling. When the insurer's adjuster investigated, he met with the insured who advised him that there was no other insurance on the premises. He, thereafter, signed and swore to a proof of loss in his attorney's office which proof contained his false statement that there was no other insurance. In fact, there was other insurance covering the dwelling and the insured was fully aware of the existence of the same.

11. 235 S. C. 452, 112 S. E. 2d 241 (1960).
12. 269 F. 2d 421 (4th Cir. 1960).

The Fourth Circuit Court of Appeals pointed out that the policy provided that,

> "The entire policy would be void if, whether before or after a loss, the insured . . . wilfully concealed or misrepresented any material fact . . ."

and that the insured knowing of the existence of the additional insurance coverage had signed and sworn to the proof of loss in his attorney's office. The Court of Appeals held that the conclusion seemed inescapable as a matter of law that the false statements on the part of the insured that there was no other insurance were made intentionally and wilfully and with the intent to deceive or defraud the appellant insurance company. Accordingly, the judgment of the lower court was reversed and judgment entered for the insurance company

In *Parker v. Progressive Life Insurance Co.*,[13] the action was by the beneficiary of a life insurance policy to recover the face amount of the policy. The policy was issued on January 23, 1956 and the insured died on March 20 of that year. The insurer refused to pay the face amount of the policy but tendered in settlement the sum of $102.64 on March 3, 1957 which the respondent refused. The action was instituted on May 24, 1958, which was more than two years after the date of the policy.

The insurer in its answer asserted a policy provision providing as follows:

> "Within two years from the date of the issuance of this policy, the liability of the company shall be limited to ten percent of the face amount of this policy under the following conditions: (1) If the insured is not alive and in sound health upon the date of issuance and delivery of this policy; or * * * (3) if within two years before the date hereof the insured has been attended by a physician for any serious disease or complaint . . ."

The answer further alleged that at the time of the issuance of said policy the insured was not in sound health and that he had been attended by a physician for a serious disease.

The tender of $102.64 represented ten percent of the face amount of the policy.

The plaintiff demurred to the Answer upon the grounds that it did not state facts sufficient to constitute a defense

13. 235 S. C. 96, 110 S. E. 2d 5 (1959).

because it was based upon alleged false representations made by the insured more than two years prior to the institution of the action and was thereby waived perforce the provisions of CODE OF LAWS OF SOUTH CAROLINA Section 37-161 (1952), which statute as applicable to this case is as follows:

> "All companies which issue a policy or certificate of insurance on the life of a person shall, after a period of two years from the date of such policy or certificate of insurance, be deemed and taken to have waived any right they may have had to dispute the truth of the application for insurance or to assert that the assured person had made false representation and such application and representation shall be deemed and taken to be true . . ."

The demurrer was sustained upon the authority of *Blackwell v. United Insurance Company of America.*[14]

The insurer would attempt to avoid the authority of the *Blackwell* case, *supra,* upon the theory that the condition of the policy was an exception to, or limitation upon, the risk assumed and is not affected by the statute. The Supreme Court said that the answer to this contention was simply that the condition is dependent upon the ill health of the insured at the time of the application for, and issuance of, the policy, or medical attention for a serious disease within the specified time. The Court said that under the statute the appellant is prevented by the passage of time from disputing the truth of the application or asserting that the insured made false representation and that applying the statute, which the Court said was as much a part of the policy as if it had been written into it, the insured's representations in his application that he was in good health, *etc.,* are true, and by the same token, the allegations of the answer to the contrary are untrue, perforce the statute, for the purpose of determining appellant's liability under the policy.

The insurer further contended that its tender of the amount which it concedes was due under the policy within two years from the date of it fixed the rights of the parties. But the Court said that such action by the insurer is not a sufficient assertion of the contended right; it must be an action in law and equity. The Court quoted authorities from other jurisdictions to the following effect;

14. 231 S. C. 535, 99 S. E. 2d 414 (1957).

> "By the great weight of authority, a contest, within the meaning of an incontestable clause in an insurance policy, means some affirmative or defensive action taken in Court to cancel the policy or prevent its enforcement, to which the insurer and the insured, or his representatives or beneficiaries are parties."

The Court further stated that the insurer was provided a remedy upon the facts that it alleges which it did not pursue by virtue of CODE OF LAWS OF SOUTH CAROLINA Section 37-162 (1952), as follows:

> "Every insurance company doing a life insurance business in this state may institute proceedings to vacate a policy on the ground of the falsity of the representations contained in the applicaton for such policy if such proceedings be commenced within two years from the date of the policy."

In *Edwards v. Great American Insurance Company*,[15] the action was to recover under a fire insurance policy insuring a one story frame tenant dwelling owned by respondent which directed that the proceeds would be payable to the respondent and to the respondent Bank of Great Falls as mortgagee, as its interest might appear. The agreed value of the dwelling was $2,000.00 and the agreed value of a barn was $500.00 and the policy was written for these respective amounts. The jury returned a verdict for the full face amount of the policy from which the defendant appeals.

In its answer, the defendant pleaded the provision of its policy prohibiting insurance in excess of the amount fixed in the valuation clause of the policy. The defendant insurance company also plead the provisions of its policy providing that where payment is made to a mortgagee under the policy where the company claims that there is no liability, the mortgagee shall assign all securities held as collateral to the mortgage debt to the insurance company who shall be subrogated to the rights of the mortgagee. As a third defense, the insurer plead that if the policy involved should not be held voided because of the additional insurance obtained by the insured, that under the laws of the State of South Carolina, the appellant could only be held liable for a proportionate amount of the insurance carried.

15. 234 S. C. 404, 108 S. E. 2d 582 (1959).

The Supreme Court held that the issue as to whether the policy had become void because of the additional insurance which exceeded the valuation agreed upon in the policy was properly submitted to the jury since there was sufficient evidence of the insurance company's waiver of this provision.

With regard to the defense relative to the subrogation of the insurer to the rights of the mortgagee, the Supreme Court held that this assignment of error could not be sustained because, under the provisions of the policy, payment by the insurer of the mortgage obligation was a condition precedent to the insurer's right to claim subrogation and no payment had been made.

However, the Supreme Court held that, unless the insured should remit upon the record a portion of the judgment as computed by the Supreme Court, a new trial would be granted. This result was reached because of Section 37-154 of the Code which provides, *inter alia,* that

> "If two or more policies are written upon the same property, they shall be deemed and held to be contributive insurance and if the aggregate sum of all such insurance exceeds the insurable value of the property, as agreed upon by the insurer and the insured, each company shall, in the event of a total or partial loss, be liable for its pro rata share of insurance."

The Supreme Court held that the appellant had two-thirds of the total insurance outstanding on the dwelling and that it would, therefore, be required to pay two-thirds of the face amount of its policy, since the dwelling had been totally destroyed and that, further, the appellant had one-half of the outstanding coverage on the barn and would, therefore, be required to pay one-half of the face amount of its policy due to the respondent.